UTAH
LABOR COMMISSION'S

Medical Fee Guidelines

based on the 2004

RBRVS Schedule and the AMA

2004 CPT

EFFECTIVE JULY 1, 2004

Division of Industrial Accidents

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I. FOREWORD

A. GENERAL STATEMENT - MEDICAL CARE REIMBURSEMENT GUIDELINES

The Utah Labor Commission is to set the fees and rules for medical providers as defined and authorized in §34-2-407, Utah Code Annotated. The Utah Labor Commission adopted its first Relative Value Fee Schedule (RVS) in 1956 and has updated and maintained a Medical Fee Schedule until this present time through the efforts of many individuals serving on the Commission's Medical Fee Advisory Committees. Current members of the medical fee committee are:

Labor Commission
Joyce Sewell – Director, Industrial Accidents
Alan Colledge, MD – Medical Director, Chair

Orthopedic Physician Representative
Gary Zeluff, MD

Primary Care Physician Representative
Mark Anderson, MD

Chiropractic Physician Representative
Ted Conger, DC

Physical Therapy Representative
Steve Crandall, PT

Workers' Compensation Representatives
Dean Sanders
Workers Compensation Fund

Peg Howarth
Workers Compensation Fund

Private Workers' Compensation Writers
Fran Paxton
Farmers Insurance

Self Insured Representative
Trish McDonald
Utah Transit Authority

Coding Expert Resource
Mari Ann Randall
INGENIX

Melissa Fonnesbeck
INGENIX

The Labor Commission, with the approval of the Workers' Compensation Advisory Council, has adopted

this 2004 Medical Fee Schedule. This schedule is based on the 2004 CMS Resource Based RelativeValue Scale (RBRVS) and the AMA 2004 CPT.

The adoption of this schedule allows recognition of the latest technology in the exchanging of information electronically through one fee schedule for all types of billings by medical providers, i.e., Medicare, health insurance, or workers' compensation from computer systems with one procedure listing.

As defined below, the Commission has adopted its own unique conversion factors for each specialty.

B. RBRVS - DEFINITION OF USE

The Centers for Medicare and Medicaid Services (CMS) Resource Based Relative Value Scale (RBRVS) has been selected as the method for calculating reimbursement using the 2004 AMA CPT-4 coded procedures for those providing care for injured workers covered under the Utah Workers' Compensation Act. A copy of the current AMA CPT may be obtained by calling 1-800-621-8335. A copy of the Resource Based Relative Value Scale (RBRVS) can be obtained by calling INGENIX at 1-800-999-4600.

- This RBRVS system uses the three variables listed below to derive a single number, referred to as the Relative Value Unit (RVU), which has been assigned to each CPT-4 code.
- **The total RVU is comprised of three distinct values:**
  Work Expense Value (WE)
  Practice Expense Value (PE)
  Malpractice Expense Value (MAP)
- To determine the total amount for reimbursement, the RVU assigned to each CPT code is to be multiplied by each specialty's unique 2004 Utah Labor Commission's conversion factor to obtain the total reimbursement value. **[Example: (2004 CPT's RVU) x (2004 Utah Labor Commission's designated conversion factor as per specialty (expressed in dollars) = the Total Reimbursement Value.**
- The Utah Labor Commission has chosen **NOT** to use CMS's designated Utah's Geographic Practice Cost Indexes, (GPCI) adjustment, but to use the non-adjusted national RBRVS to calculate reimbursement values. This will **simplify** calculating current reimbursement rates by providers and payors, and also, facilitate the Labor Commission's yearly updates and comparative studies.

ASSIGNED CONVERSION FACTOR DOLLAR AMOUNT

- **July 2, 2004, the Utah Labor Commission's conversion factor to be used with the RBRVS procedural unit value as per specialty will be:**

Medicine, E & M	**$42 (New)**
Restorative Services	**$42 (New)**
with Codes 97001 & 97003 at 1.5 RVU and Code 97002 & 97004 at 1.0 RVU	
Surgery	**$37**
All codes in the 20000 and 60000 sections and codes 49505 thru 49525	**$58**
Radiology	**$53**
Anesthesiology	**$41**
Pathology and Laboratory ** (See below)	

- *** Anesthesia:** Medicare's Base Units and methodology for time calculation **(1 unit for 15 minutes of anesthesia)** is adopted with the conversion factor listed above.

- **** Pathology and Laboratory:** The current RBRVS identifies values for specific codes that

require the pathologist services. All other reimbursement rates for laboratory and pathology codes will be 150% of the Utah Medicare Laboratory Fee Schedule. A copy is available through the Medicare carrier (Blue Cross/Blue Shield) of Utah.

- **Setting for Procedure**: The physician must identify the setting where the procedure was performed when billing.

  Provided in an office or clinic setting: These procedures are reimbursed using the Non-Facility Total RVU, with the exception of injections of a type of which cannot be self-administered, and if they are directly related to the treatment of an injury or direct exposure or condition. Splints, redressing materials and casting supplies are payable separately under the Labor Commission's supply provision rule – R612-2-16. In addition, unusual services and medications may be billed separately if identified with a -25 modifier and supported by documentation.

  Provided in a facility setting: These procedures for physician services are reimbursed using the Facility Total RVU for the calculation of payment as the facility will be billing for the direct and indirect costs related to the service.

- **Non Assigned CPT Codes:** For those few codes not listed in Medicare's RBRVS Fee Schedule or INGENIX/Publishing/Medicode, contact the Labor Commission to see if a reimbursement value has been assigned.

C. MAXIMUM ALLOWABLE FEE

1. **The RBRVS Fee Schedule is the maximum fee for a procedure used with the Utah Labor Commission's conversion factors for each specialty.** The RBRVS, through an intense study of input, is based on the resources needed to accomplish a particular procedure, and thus, an unusual method in itself does not warrant an increased fee. A physician should not charge more than his/her usual fee. Items that are a portion of an overall procedure are **not** to be itemized or billed separately.
2. **If an employer or carrier has a contract with a provider for discounted service given to an injured worker, the discount applies.** If there is no contract, then the RBRVS fee schedule applies.
3. **Rounding to the Nearest Dollar:** Carriers may calculate fees ending in odd cents by rounding to the nearest dollar; round down for $.49 or less and round up for $.50. If this is done on some charges, it must be done with all charges. If the medical provider has rounded all individual fees, the total of these fees should be paid as submitted, by recognizing that in any given series of bills, this may represent a trivial under payment or over payment that will average out with time.
4. **Consultation:** Initial evaluation and subsequent services are designated as listed in Levels of Service. Visits and consultations should be placed in the proper category for the level of service. A referral may ensue after completion of a consultation, but such an event does not preclude the fact that the initial evaluation was, indeed, a consultation. Only advice and/or an opinion should be rendered for consultation services. Care and treatment of the patient should not be undertaken without a clear and mutual understanding between the treating physician and the consulting physician.
   Referral: A referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation
5. **Emergency Room Consultation:** When a physician is called to the emergency room to see and assume the care of a patient in his specialty, he can make a charge for a consultation prior to surgery using a -57 modifier. (New) In the case of a non-surgical admission, one cannot charge for a consultation in the emergency room and, also, for a work-up for the hospital admission.
6. **Professional - Technical Billing:** Each service rendered will be reimbursed one time. If the service has a professional and technical component, billed by separate entities, each will be reimbursed by their respective component. A second interpretation may be covered when pre-authorized with the payor.
7. **After Hour Coverage:** Utah's Guidelines are consistent with the RBRVS using the standard Medicare guides. Codes 99050 through 99058 are used to identify emergency and after hour care.

II. GENERAL GUIDELINES - MEDICAL CARE

A. MEDICAL CARE GUIDELINES

- **An injured employee is entitled, without personal expense, to medical care, treatment, and hospitalization reasonably necessary, up to the limits prescribed by the law.** The physician should always bear in mind that the payor must make his/her decision based on the information provided by the physician. If the physician has not sufficiently documented the treatment given and the reasons for that treatment, the payor may consider treatment unreasonable or unnecessary.
- **It is the prerogative of the attending physician to determine the type, duration and frequency of treatment, including hospitalization and nursing services.** Such services must be provided in accordance with recognized professional standards for the type of injuries incurred. Services in addition to those prescribed or ordered by the attending physician, must be paid for by the patient.
- **Billing for "new patient":** A physician may bill the new patient E & M code when seeing an established patient if there is a new injury.
- **Discharge from the hospital, or transfer to a facility of a lesser nature, should be done at the earliest time appropriate to good medical practice.** Extended-care facilities should be utilized when necessary. In certain cases, arrangements should be made with the carrier for home care. Payment for hospital care is limited to the bed rate for a semi-private room. If the patient requests a more private hospital accommodation without medical documentation of need, the patient will be responsible for the difference personally. The physician should also use special hospital units, such as intensive care, only to the extent necessary. Special nursing care is rarely required, due to the intensive or critical care units in hospitals, but can be utilized if necessary.

1. **Excessive Charges**

   A charge is excessive if any of the following conditions apply to the charge:
   a. The charge exceeds the amount for the type of service allowed in the medical fee schedule of this chapter, or
   b. If not specified in the RBRVS fee schedule, the charge exceeds that which prevails in the same geographic community for similar services or treatment, or
   c. The charge wholly or partially duplicates another charge for the same service, such that the charge has been paid or will be paid in response to another billing.

2. **Excessive, unnecessary or questionable Services**

   No payment is to be made for a service which is considered to be excessive, or questionable to the degree that any of the following standards apply:
   a. The service is not listed in this schedule or, the service does not comply with the standards and requirements concerning the reasonableness and necessity, quality, coordination, and frequency of services; or
   b. The service was performed by a provider prohibited from receiving reimbursement; or
   c. The service is not usual, customary, and reasonably required for the cure or relief of the effects of a compensable injury, or
   d. The service is not listed in the RBRVS schedule.

3. **Medical Necessity**

All services and supplies provided to injured workers **must be medically necessary**. Medically necessary means any medical service or supply which is:

a. Provided as remedial treatment for an on-the-job illness or injury, or
b. Appropriate to the patient's diagnosis, or
d. Consistent with the location of service, or
e. Consistent with the level of care provided, or
f. Widely accepted by the practicing peer group, or
g. The service is not listed in this medical fee schedule.

4. **Billing Disputes**

a. To resolve billing disputes, the Labor Commission utilizes this medical fee schedule and other standard industry protocols including, but not limited to, the **Complete Global Service Data for Orthopaedic Surgery**, published by the American Academy of Orthopaedic Surgeons.
b. The charge exceeds the provider's current charge for the same type of service in cases unrelated to workers' compensation injuries; or
c. The charge does not comply with standards and requirements, concerning the cost of treatment; or
d. The charge is described by a billing code that does not accurately reflect the actual service provided.

B. HOSPITAL REIMBURSEMENT

The Labor Commission does not have a hospital facility fee schedule. However, **reimbursement for hospital services performed by a physician** as defined in § 34A-2-111, UCA, **is subject to the Utah fee schedule** per §34A-2-407(8)(b). Carriers and self-insured employers may reimburse hospitals per contracted rates or UCR.

PHYSICIANS SERVICES
Physicians in the State of Utah are defined as doctors of Medicine, Osteopaths and Chiropractic, who are licensed as physicians to practice in the state of Utah. For payment purposes, the definition of physician is 34A-2111 UCA.

C. NON-PHYSICIAN SERVICES

The following medical providers may provide services only under the direction of, or by the prescription of, a licensed physician: Registered physical therapists; Registered occupational therapists, Registered nurses; Licensed practical nurses; Licensed psychologists, speech pathologists and audiologists, and physician extenders. All such services rendered by non-physician providers will either be billed separately by the physician or itemized and identified as a portion of the bill of the physician (except for physical therapist or occupational therapists services in their own field). (See Modifier +-83)

Certified, registered nurse anesthetists may also bill separately, but must be identified by their credentials on the billing. (See Modifier +-83)

Massage therapists, Acupuncturists, Naturopathic providers may only provide care if the care has been pre-authorized by the payor.

D. SURGICAL PRE-AUTHORIZATION

As required by rule R612-2-4, "Hospital or Surgical Pre-Authorization, "Any ambulatory surgery or inpatient hospitalization, other than a life or limb threatening admission allegedly related to an industrial injury or occupational disease, shall require pre-authorization by the employer/insurance carrier."

E. CHANGING OF CODE NUMBERS ON BILLINGS

Physicians' code numbers on billings are to be supported by the appropriate documentation as to the level of service or code billed. **Disagreements between carrier and physician as to code changes have been addressed in the Labor Commission's Rule R612-2-24, "Review of Medical Payments."** If the disagreement cannot be worked out between the carrier and physician, the Labor Commission will review the issue and make a final ruling as per II-1-D of the above mentioned rule.

A processor of industrial fee claims may change the code number supplied by the physician under the following circumstances:

1. When there is a code that more clearly identifies the nature of the services than the code used by the physician.
2. When the identified service is a portion of a larger procedure and included in the fee for the larger procedure, such as "global services."
3. When the number is incorrect for the services described.

Whenever a code number of a physician's bill is changed by a reviewer, the reason for that change **must be** identified to the physician with his payment **as per Labor Commission Rule R612-2-23, "Adjusting Relative Value Schedule (RVS) Codes."** The physician should be given the name and phone number of the claims processor, and the physician advised to call, if necessary, and discuss the matter if unsatisfied. **The procedure for resolving disputes over fees for medical services is addressed in the Labor Commission's Rule, R612-2-24, "Review of Medical Payments."**

III. UTAH LABOR COMMISSION SPECIFIC GUIDELINES

A. MODIFIERS

1. **In addition to modifiers defined in the current CPT schedule, the Utah Labor Commission has identified the following to also be used for workers' compensation medical care:**

   -83 Assistant Paramedical Personnel: In limited circumstances, services may be performed by paramedical licensed personnel as listed below, under the supervision of a licensed physician. These should be billed for by the physician at the percentages listed below of the amount that would be paid had a physician performed those services. These individuals should be qualified, competent and licensed in the state of Utah to carry out the services performed. They may include the following:

Physician Assistants	75%
Nurse Practitioners	75%
Medical Social Workers	65%
Nurse Anesthetists	75%
Psychologists	75%

Modifiers: Clarification on:

80 for Assistant Surgeon: MDs, DOs, and Podiatrists
81 for Minimum Assistant Surgeon: Defined as PA and NP at (75% Surgeon)

*A listing of procedures that qualify for an assistant at surgery can be found at:
http://cms.hhs.gov/providers/pufdownload/rvudown.asp

Paramedical individuals billing separately

Other paramedical assistants, including surgical assistants are not to bill separately for work on industrial injury workers.

Home Health Care *

RN	75%
LPN	55%
Home Health Aide	50%*

The codes billed for home health care include travel time.

TC **Technical Component:** Under certain circumstances, the technical component alone may be identified. [See definition of technical component under Radiology Ground Rules.] Under those circumstances, the technical component is identified by adding this modifier (TC) to the usual procedure number.

For Home Health Codes 99500 through 99602

All include mileage and travel time.
RN $80/2hr.
LPN $55/2hr.
Home Health Aide $15/hr. + $6 additional 30 min.
Speech Therapists $75/visit

B. MULTIPLE OR BILATERAL INJURIES OR SURGICAL PROCEDURES PERFORMED AT THE SAME OPERATIVE SESSION - (Use Modifiers -50 and -51)

1. **Primary Procedure:** Should be billed at 100% of the profile fee.
2. **Lesser Procedures:** These are called secondary procedures performed through the same operative incision, or that are performed in the same general operative area, which add significant time or complication shall be billed at 50% of the relative value, unless they are an integral part of the primary procedure, in which case no additional fee is charged.
3. **Should Not Bill:** Procedures that are uneventful and performed through the same incision or in the same operative area and do not add significant risk or time to the primary procedure. **Examples:** Lysis or excision of scar tissue, a reasonable amount of debridement, removal of loose bodies, etc.
4. **Should Not be Billed for in Addition To:** Care of wounds, including debridement in connection with open fractures or other deep structures requiring repair such as tendons, nerves, bone, blood vessels, etc., **unless** the laceration or wound necessitates a surgical procedure **significantly greater** than the operative incision that would have been necessary for repair of the underlying structures.
5. **Secondary Surgical Procedures Performed at the Same Operative Session,** but, requiring a separate, remote operative site and preparation from any other, shall be billed at 75% of the profile.
6. **Second and Additional Surgical Procedures in Each Incision, Area, or Region** will be billed at 50% of the unit value.
7. **When medical care is the treatment of one injury and surgical care is the treatment of a separate injury,** bill both at 100% of usual fees if they represent significant time and complication of treatment. Routine care of these minor non-surgical injuries carried out in conjunction with major injuries should only be billed in addition when they add significant complexity or time to the care that would be required by the major injuries.
8. **Diagnostic arthroscopy** should be billed at 50% when followed by open surgery.
9. There is **no separate fee** when it is followed by arthroscopic surgery.
10. **Whenever the descriptor refers to "each,"** the rules for **multiple** surgery apply.
11. **Spinal procedures are coded and reimbursed based on the current CPT. When performing bilateral**

injections, use the 50 modifier unless otherwise defined by the CPT. Maximum of six (6) spinal injections per visit. Preauthorization required.

12. **Summary:**
    Primary Procedure B 100%
    Secondary Procedures Same Incision, Region or Area -- 50%
    Secondary Procedures in Remote Areas -- 75%
    Additional Procedures -- 50%
    Bilateral B -- 75%
13. **See Integument System for lacerations.**

C. COST OF MATERIALS (COM)

Certain supplies and materials are to be provided by the physician that are usually included with the visit or other services performed. Fees covering ordinary dressings, materials or drugs used in diagnosis and treatment shall not be charged for separately, but shall be included in the amount for the office or hospital treatment. If the record of the case shows that it was necessary to use an extraordinary amount of dressing material or drugs, these will be paid for using - ALPHA - Numeric HCPCS Level II Codes. Special materials and supplies may be billed at cost plus 15%.

D. SPECIAL REPORT - Use of CPT Modifier -22 when coding for these services and should include medical document support.

A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure; and the time, effort and equipment necessary to provide the service. Additional items which may be included are:

The medical provider is asked to provide a narrative or treatment summary;

- Fill out forms for the patient or payor, or answer questions that are not included in the usual required reporting for the Evaluation Management codes.
- Complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow up care.

Recommendations: In this particular situation, a physician should provide supporting documentation and **may bill for the extra time necessary to complete information** that is in addition to the usual required reporting code:

E. NON COVERED PROCEDURES

"Category III T Codes" are experimental codes and are currently not covered procedures for Utah's injured workers.

IDEPT, percutaneous discectomies and other heat or chemical treatments for discs along with thermo rhizotomy's are still considered investigational. Further research is needed to demonstrate value to Utah's Injured workers before assigning any reimbursement value.

F. CODES WHICH MAY NOT BE BILLED - "NO CHARGE" (NC) CODES LIST:

93760 & 93762	Thermograms
95832 (part of E&M)	Muscle testing

95833 (part of E&M)	Muscle testing
95834 (part of E&M)	Muscle testing
96000	Computer based motion analysis
96001	With plantar pressure measurements
96002	Dynamic Surface EMG
96003	Dynamic Fine Wire EMG
96004	Physician review and interpretation of comprehensive based motion analysis
97005	Athletic Training Evaluation
97006	Athletic Training Reevaluation
99090 (part of E&M)	Analysis of data, now BR

Special note: BILLED AS SUPPLIES, REIMBURSED AT COST + 15%

99071	Educational supplies

G. WORKERS' COMPENSATION RULES - HEALTH CARE PROVIDERS

(Refer to pages 25-32 for the text of the rules)

1.	Definitions	R612-2-1
2.	Authority	R612-2-2
3.	Official Forms	R612-1-3
4.	Supply rule	R612-2-15
5.	Utilization Review Rule	R612-2-26
6.	Restorative Service Rule	R612-2-3
7.	Medical Disputes	R612-2-24
8.	Discounting (Lump Sums Settlement)	R612-1-4
9.	Interest (on benefits)	R612-1-5
10.	Hospital or Surgery Pre-Authorization	R612-2-4
11.	**Regulation of Medical Practitioner Fees [Amendment Effective Jan 1, 2001]**	**R612-2-5**
12.	Fees in Cases Requiring Unusual Treatment	R612-2-6
13.	Who May Attend Industrial Patients	R612-2-8
14.	Insurance Carrier's Privilege to Examine	R612-2-7
15.	Changes of Doctors and Hospitals	R612-2-9
16.	Interest for Medical Services	R612-2-13
17.	Hospital Fees Separate	R612-2-14
18.	Charges for Ordinary Supplies, Materials or Drugs	R612-2-15
19.	Charges for Special or Unusual Supplies, etc.	R612-2-16
20.	Fees for Unscheduled Procedures	R612-2-17
21.	Dental Injuries	R612-2-18
22.	Ambulance Charges	R612-2-19
23.	Travel Allowance and Per Diem	R612-2-20
24.	Notice - Denial of Liability	R612-2-21

H. RESTORATIVE SERVICES GENERAL GUIDELINES FOR REIMBURSEMENT

1. **Restorative services are an integral part of the healing process for a variety of injured workers.** Recognizing this, the Utah Medical Fee Schedule includes codes for restorative services, i.e., those modalities, procedures, tests, and measurements in the Physical Medicine Section, codes 97010 through 97750, representing specific therapeutic

procedures performed by medical doctors, chiropractic physicians, licensed physical and occupational therapists and other physicians. **The following criteria must be met in all cases where restorative services are rendered in order for a service to qualify for reimbursement:**

a. The patient's condition must have the potential for restoration of function.
b. The treatment must be prescribed by the authorized attending or treating physician.
c. The treatment must be specific for the improvement of the patient's condition.
d. **The restorative services must be provided under the reporting requirements of rule R612-2-3 of the Workers' Compensation Rules and Regulations of the Labor Commission:**
   - The chiropractor shall file Form #123, "Physicians Initial Report," with the Labor Commission and the carrier/self-insured employer within one week of the initial examination.
   - S.O.A.P. Notes (subjective, objective, assessment and plan/procedure) or progress notes must be sent to the insurance carrier/self-insured employer by all providers at the time of billing or at the request of the Commission, insurance carrier or self-insured employer.
   - All providers billing under the restorative service section shall file a Restorative Services Authorization Form #221 with the insurance carrier/self-insured employer and the division within 10 days of initial treatment. All such providers must submit progress notes or a progress summary when billing for services and on request by the insurance carrier.
e. The physician or therapist must be in constant attendance during the providing of services.
f. Physical therapy, consisting of modalities only, is generally inappropriate beyond the first visit post-injury, unless the treatment also includes hands-on-procedures. A program of home treatment should be considered when modalities are the only treatment needed.
g. For acute conditions, the patient should be closely followed by the physician, with no less than one physician follow-up every three weeks.
h. Daily therapy is rarely needed, with documentation of objective improvement per RSA rule utilizing the form **221.**
i. In addition to the foregoing, there is an affirmative duty placed on the provider of restorative services to teach the patient the principles on which therapy is based, as well as those parts of the therapy which he, the patient, can self-administer. This should be done under supervision during restorative treatment in order to maintain the level of function achieved during the restorative therapy. When it is determined that no further restoration can be achieved from therapy, the design of a independent maintenance program and the instructions for carrying out that program for patient must be concurrently completed in order that additional cost may not be incurred. Therapy performed by the patient, or other lay person, after proper instruction, is not reimbursable, even when supervised by a therapist or physician.
j. When patients do not show measurable progress, further treatment will not be reimbursable, per RSA 221.

2. Special Services

a. "Work hardening" and similar programs are to be billed using the listed physical therapy schedule. More specific and comprehensive programs are rehabilitative in nature and thus not covered separately, but may be undertaken upon agreement with the carrier pursuant to “b" [See below].
b. If the carrier is of the opinion that these special services are desired for their purpose they may authorize in advance with payment agreed upon, including duration, frequency and number of treatment visits.

3. Mechanized/Computerized Evaluation with Printout of Joint/Muscle/Trunk Function Whether Isotonic, Isometric and/or Isokinetic and Functional Evaluations of Patient and Capabilities.

a. All assessments/evaluations should be done only when necessary and shall be consistent with the patient's medical diagnosis and dysfunction. The assessment shall be for the

benefit of therapy and not for purposes of research.

b. Such testing requires a specific prescription by the physician.
c. Standardized testing and/or testing with special standardized equipment should be done on patients where such information is needed to establish an adequate baseline on which to base treatment, establish functional skills relative to the job, or serve as a baseline to objectively monitor patient progress.
d. Such equipment should be reputable with appropriate and reasonable information available on reliability and validity. Where appropriate, the subject can serve as the control for normal and, where available, other normal performance guidelines should be used as reference.
e. Standardized tests utilized shall be appropriate to the type of disability, have norms for **the subject's age and have standard administration procedures.**
f. A report is to accompany the bill.

4. Multiple Treatment Areas

For multiple treatment areas when treatment is pre-authorized to more than one area, a single office visit charge will remain, and not over two additional modalities can be billed for.

5. Transcutaneous Electrical Nerve Simulators (Tens)

- TENS must be prescribed by a physician or under the physician's prescription. (See 64550.)
- Prior diagnostic testing must be performed to determine the efficacy of TENS in control of the patient's chronic pain.
- TENS testing and training is limited to four (4) sessions and a 30-day trial period. To exceed this limitation, written documentation of a medical necessity is required.

6. Maintenance or Palliative Treatment

a. Since the maintenance of health is of benefit to everyone and an individual responsibility, utilization of fitness centers and associated equipment or services solely for health maintenance is not covered under workers' compensation.
b. Since workers' compensation services must be medically necessary in the treatment of on-the-job illness or injury, no reimbursement will be made for medical services rendered for the prevention or the recurrence of illness or injury.

7. Maximum Allowable Procedures

"All medical providers billing under CPT codes 97001 thru 97703 are subject to billing the maximum of three procedures per day. This may include an evaluation code for the office visits, plus up to two additional modalities. If no office visit evaluation code is billed, then up to three modalities may be billed."

The Utah Labor Commission recognizes the entire spine as one region, for billing purposes.

8. Physicians - Office Visits and Modalities

Under most circumstances, medical, osteopathic, chiropractic physicians performing restorative services will use the 99201 or 99202 code for new patients and 99211 or 99212 for established patients. Other office medical codes in the most current AMA CPT-4 may be used when warranted, and when they are substantiated by a report of the examination performed which specifies the findings of the examination and the subsequent treatment rendered.

All services performed should be itemized, even if not billed (NC).

9. Physical Therapy Provided by Physicians (MD's)

a. **Initial Office Visit (New Patient)**: A physician may charge and be reimbursed for an initial office visit to examine and evaluate the patient and perform physical therapy.

b. **Follow-up Office Visit (Established patient)**: A physician may charge and be reimbursed for a follow-up visit and physical therapy only if new symptoms present the need for re-examination and evaluation. Documentation of medical necessity must be submitted for reimbursement to be made and the new diagnosis must be reported to the carrier on the proper form.

10. **Electrophysiologic Testing**

a. **Referrals for Testing:** Physicians referring patients for electrophysiologic testing should provide the testing physician with specific information about the patient. This information would include, but not be limited to, the working diagnosis, prior testing results, and what issues the electrical testing is to clarify.

b. **Testing with Electromyography and Nerve Conduction Studies:** There are situations in which both electromyography and nerve conduction studies must be accomplished, such as when defining whether a neuropathy is of demyelinating or axonal type. Seldom is it required that both studies be accomplished in straightforward conditions of median and ulnar neuropathies or peroneal nerve compression neuropathies.

c. **Multiple Extremity Testing:** It is rarely necessary for more than two extremities to be examined, and it is never necessary for four extremities to be examined.

d. **Radiculopathies:** There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of a spinal root process, (radiculopathy).

e. **Number of tests to be completed:** To list each specific nerve which might be studied and determine limits of the study techniques permitted is not practical. There must be a latitude provided to the examining physician which permits judicious and appropriate extension in the examination as required by the types of abnormalities be identified. Clearly, if normal values are being recorded, there is, in most cases, less, rather than greater justification for extending the scope of the examination.

f. **Reimbursement**: The reimbursement for electrophysiological testing under the current RBRVS is adequate, and includes both a professional and technical fee. If the physician uses a facility's equipment and/or technician for the testing, the bill submitted will be for the professional component only with a modifier -26.

g. **Upper Extremity:** Distal entrapment syndromes, encompassing the median and ulnar nerves, are generally readily suspicioned and clinically diagnosed conditions, known by most physicians. In the case of presumed carpal tunnel syndrome, the ulnar nerve in the same extremity should also be tested to evaluate for the possibility that multiple neuropathies are present in the same extremity. If both the median and ulnar values are abnormal, the patient's other extremity should then be examined to assess for the possibility of there being widespread polyneuropathy. Charges for the mid-palmer parameters, or inching techniques, should not be greater than charges for routine single nerve stimulation.

h. Lower extremity: A similar situation would be appropriate should the patient be under evaluation for a condition that involved one lower extremity neuropathies.

i. **Who should Perform Tests on Utah's Injured Workers:** Electromyographic examinations on industrially-injured patients in Utah should be accomplished by physicians. Nerve conduction studies should be done by a qualified technician working directly under the supervision of a physician, **billing** at the percentages listed under section III, page 11, (75% of the amount a physician would be paid had a physician performed those services). These individuals should be qualified, competent and licensed in the state of Utah to carry out the services performed.

IV. UTAH LABOR COMMISSION SPECIFIC CODE GUIDELINES

Some variances in the Utah adaptation of the RBRVS have been made to allow for more clarity of the services rendered relating to billing.

Unless otherwise identified in the following, the most current AMA CPT-4 coding guidelines apply for Medicine, Evaluation & Management, Restorative Services, Radiology, Pathology & Laboratory, Anesthesia, and Surgery.

A. MEDICINE

1. **Impairment Rating**

a. The treating physician is the person most knowledgeable regarding the condition, progress, and final status of the injured employee and, for this reason, should be in the best position to render an impairment rating, and is encouraged to do so.
b. The rating should be based solely on the objective maximum achieved condition of the patient. This service of calculating an impairment is not considered a portion of any of the services previously rendered and is not included in the routine post-operative care. There are special code numbers for payment for this service. The attending physician is encouraged to complete the case unless he feels that there is some specific reason that the doctor-patient relationship may be impaired by making such a determination.
c. If for any reason the attending physician prefers to not make this evaluation, the insurance carrier should be notified in order that a decision can be made as to a proper referral for the evaluation. The physician may make a recommendation to the carrier of a proper referral.
d. The following codes are used to report evaluation and management services provided to patients when the physician is providing an impairment rating to the insurance carrier and/or employer. Impairment ratings include evaluation of the patient, review of records, and diagnostic studies where necessary.
e. The **Medical Report at Stability** is a comprehensive report prepared after the injured worker is medically stable. As this is an administrative document, the final disposition of the examiner should include the following information:
   - **Diagnosis:** The examiner needs to clearly state the diagnosis and have it clearly substantiated from the medical record. The examiner should also define, as best as possible, their impressions as the relationship of the diagnosis and the industrial event. It is recognized that in many cases specific pathologic diagnoses are not clearly evident. The examiner has the responsibility to provide a diagnosis as valid as the clinical findings allow.
   - **Stability**: The examiner must declare the patient medically stable. The examiner must state that it is his/her medical opinion that all that can be done medically for the patient has been done, and that the patient is not expected to improve with further medical care and/or time. It is important to note that "medical stability" does not always mean that ongoing care is not needed.
   - **Calculation of Impairment**: Using valid, standardized rating criteria, the examiner should calculate the residual impairment, based on clinical findings established in the medical record.
   - **Apportionment**: The examiner must identify and list any factors, physical and non-physical, which add to the impairment, but are not directly resultant from the injury.
   - **Capabilities Assessment**: Following the guidelines established by the U.S. Department of Labor, a limited functional capacity assessment should augment the medical record. Not only does this clearly establish physical abilities, but also facilitates the patient/employer relationship for return to work. (See Physical Demands Characteristics of Work Chart in the Guide to Impairment Rating Fourth Edition.)
   - **Future Medical Treatment**: The examiner should identify future medical treatment that may be required to maintain the stability of the patient's medical condition.

2. **Impairment Rating by Treating Physician**:

The following codes are used to report the impairment rating by the treating physician. For an impairment rating by an independent physician see code 99466.

Codes 99455 and 99456 are to be used by physicians on the final visit when stability is declared. These codes are to be used alone and **include** concurrent evaluation and management services.

Utah Code		Utah Value
99455	Work related or medical disability examination by treating physician that includes: completion of a medical history Commensurate with the patient's condition – performance of an examination commensurate with the patient's condition – formulation of a diagnosis, assessment of	2.0

capabilities and stability, and calculation of impairment – development of future medical treatment plan – and completion of necessary documentation/certificates and report. With 2.0 RVU assigned/30 min.

3. **Impairment Rating by Independent Physician**

99456	Work related or medical disability examination by other than the treating physician that includes: completion of a medical history commensurate with the patient's condition – performance of an examination commensurate with the patient's condition – formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment – development of future medical treatment plan – and completion of necessary documentation/certificates and report. Assigned 2.65 units /30 min.	2.65

2.

4. **Special Medical Evaluations (Independent Medical Examinations)**

Special Medical Evaluation is specialized evaluation of an ill or injured patient. These exams are initiated or requested by the insurance carrier or their authorized agent. An independent medical exam includes detailed review of medical records for the patient, which may include treatment prior to the date of injury. This review of records will include, but is not limited to chart notes, dictations, radiology reports and laboratory studies. Independent medical exams also include a complete and thorough physical exam of the patient. A detailed report includes findings and conclusions from the record review and the physical evaluation of the patient must be submitted to the carrier. Reimbursement for these services is based upon agreement between the carrier and provider and should reflect the time and skill to provide the independent medical exam. Services rendered that are beyond the scope of consultations, referred as **Special Medical Evaluations**, **must be agreed upon ahead of time and are outside the scope of the RBRVS.**
The following code is to be used to report special medical evaluations:

Code

99469 Special Medical Evaluations that includes review of records and diagnostic studies, evaluation of the patient and report.

Reimbursement for Special Medical Evaluations will be given individual determination.

B. RESTORATIVE SERVICES

1. Some variances in the Utah adaptation of the RBRVS have been made to allow for more clarity of the services rendered relating to billing for restorative services, which includes medical, osteopathic and chiropractic physicians, and occupational and physical therapist services. All Restorative Services **must conform** to the Labor Commission's Restorative Rule R612-2-3. "Filings." RSA Form 221 must be submitted to the carrier or self-insured employer for authorization. **Some changes have been made in either the unit value or the Utah created procedure codes of some of the associated services.**

The following codes have **no assigned RVU and, therefore, will not be paid.**

* 97020 Microwave Therapy
* 97024 Diathermy
* 97026 Infrared Therapy
* 97028 Ultraviolet Therapy

2. **Codes which have a "No Charge" (NC) Value**:

* 97005 Athletic Training Evaluations
* 97006 Athletic Training Reevaluation

3. Physical Therapy/Occupational Therapy

a. Physical therapists will use codes 97001 thru 97770, except in special circumstances. In addition to this office basic charge, they may bill for not more than 2 additional modalities/procedures from this section per day when necessary and performed. Please identify all procedures performed in the medical record, even if not billed.
b. Physical therapists may make additional billing, when justified, under special circumstances. Such additional billing requires prior authorization from the appropriate carrier. Such additional billing can be accomplished by using the Physical Medicine codes 97001 thru 97750. An example of such a special circumstance would be if the therapist were treating a neck and an arm, or a spine and a leg, at the same visit.

Code		Utah Value
97001 & 97003	Per CPT descriptor and only used one time per patient.	1.5
97002 & 97004	should not be used as an office charge only, but must reflect that a reevaluation was necessary and performed. Generally this should only be used every 6 visits, unless there is objective documentation that an evaluation and modification of treatment was necessary.	1.0
97010	Application of a modality to one or more areas; hot or cold packs.	0.11

c. Two or more areas of the spine will not be considered a special circumstance, as the spine shall be considered one unit. **The Utah Labor Commission recognizes the entire spine as one region.** (This also applies to manipulation provided by physicians only.)
d. All services provided should be itemized even if not billed.
e. Independently practicing registered physical or occupational therapists:

- To be considered independently practicing a therapist must operate a private office or rehabilitation clinic devoted exclusively to providing rehabilitative services to patients.
- The office or clinic must have its own professional license from the applicable local government.

f. Registered therapists may bill for services related to range of motion (ROM) exercises and gait training. Reimbursement may be made for ROM exercises for a specific disease or injury only when training for those services are performed by a licensed therapist (See Procedure Code 97110). Reimbursement may be made for gait evaluation and training for claimants impaired by neurological or skeletal abnormalities (See Procedure Code 97116). However, records must reflect the degree of loss resulting from the specific disease or injury, as well as the degree of restoration attributable to the therapy program.
g. An independently practicing therapist may be requested by a physician or other party to provide a written assessment to assist in the determination of the degree of restorative potential and the development of a treatment plan. This independent assessment by a therapist is reimbursable as a separate service only when treatment is not assumed by the evaluating therapist or his or her associates in a clinic. Necessary consultation between the physician and therapist to develop or modify an individual plan of treatment administered by the same therapist is a necessary service and is included as part of the allowance for procedures and therapies provided to the patient. For this service, use the appropriate most current AMA CPT-4 consultation code.

- A physical therapist is not to charge for a consultation and/or a report unless this service is specifically requested.

4. Manual Therapy Techniques

Code

97140 **For coding purposes the Utah Labor Commission recognizes the entire spine (head to pelvis) as one region and multiple spine codes are not to be used more than one time per treatment session.**

5. Osteopathic and Chiropractic Manipulative Treatments

98925 Osteopathic manipulative treatment (OMT) one or more body regions

For coding purposes the Utah Labor Commission recognizes the entire spine (head to pelvis) as one region and multiple spine codes are not to be used more than one time per treatment session.

98940 Chiropractic manipulative treatment (CMT):
spinal, one or more regions

For coding purposes the Utah Labor Commission recognizes the entire spine (head to pelvis) as one region and multiple spine codes are not to be used more than one time per treatment session.
The Utah Labor Commission does not recognize CPT codes 98941 and 98942 for coding purposes.

6. Educational Codes/Work Conditioning and Work Hardening Codes

The most current AMA CPT-4 codes are applicable with the following definitions: [See the CPT-4 time increments.]

Code

97530 To be used per the descriptors in the 2004 AMA CPT-4. and billed within capitation limits.
97535 **Individual Education and Training -** Patient education to improve functional performance at work, work modification education and self care/home management training. This includes training in activities of daily living (ADL), lifestyle changes, and making specific recommendations and restrictions, if needed, to accommodate the patient's return to work. Direct one-on-one contact by the provider. Billed outside the capitations with a limit of 4 units per injury claim.
97537 **Community/Work Reintegration Training -** (e.g., shopping, transportation. money management, avocational activities and/or work environment-modification analysis, work task analysis), direct one-on-one contact by provider.
97545 **Work Conditioning/Work Hardening** - A licensed practitioner, supervised, work-related, intensive goal-oriented treatment program specifically designed to restore an individual's systemic, neuro-muscular-skeletal (strength, endurance, work conditioning should only be continued as long as objective improvement by the patient is documented. **Pre-authorized: (Provider to specify amount of time anticipated, initial two hours). (each additional hour use code 97546)**
97546 **Work Conditioning/Work Hardening Pre-authorization (each additional hour)**
97150 **Group Education**: Training and activities of daily living, life style changes, actions to improve functional performance and work modification where appropriate in groups of 2 or more. **(Pre-authorization is required per 30 minutes billed outside of capitation. Limit of 4 units per injury claim.)**

7. Functional Capacity Evaluations

a. **Limited Functional Capacity Evaluations (97750)** - Definition: "This determines a person's dynamic maximal repetitive lifting, walking as patient reported standing and sitting tolerance.

Applications - This test is used primarily to determine a patient's functional ability profile level to be Determined by a physician following the description of the Utah Medical Association's publication of "Work place Functional Ability: Medical Guidelines." This test can be used to determine if an individual is progressing or has reached a plateau as related to function. The test may also be used to work restrictions and to assist employers in determining accommodation.

(Provider to specify amount of time anticipated)
Maximal time: 45 minutes (15 minute segments)
Pre-authorization required
Limit 1 FCE per patient with additional FCEs needing pre-authorization.

b. **Full Functional Capacity Evaluations (97750)** - Definition: This test describes information concerning an individual's maximum and repetitive lifting, walking, standing, sitting, range of motion, predicted maximal oxygen uptake, as well as ability to stoop, bend, crawl or perform work in an overhead or bent position. In addition, this test includes reliability and validity measures concerning the individual's performance (i.e., grips, tests, repeated strength tests or distraction tests). Optimal measures may include isometric testing, pushing, pulling, hand dexterity, grip strength, etc.

Applications: This test is used to determine a patient's general physical capability. It may be used when no job description is provided or the individual does not have a job to return to. This test is helpful for vocational rehabilitation counselors to determine capabilities for retraining into a different vocation. In addition, this test can be used to make disability and/or Social Security determinations. This can be used to make future recommendations.

97750 Full Functional Capacity Evaluation: **(Provider to specify amount of time anticipated.)**
Maximum time: up to 2.5 hours (15 minute segments)
Pre-authorization required

c. **Work Capacity Evaluation (97750)** - Description: This test determines a patient's capabilities based on the physical aspects of a specific job description. The capabilities measured may vary greatly depending on the physical requirement of the job that the patient is to be compared against.

97750 Work Capacity Evaluation: **(Provider to specify amount of time anticipated.)**
Maximum time: up to 2 hours (15 minute segments)
Pre-authorization required

Application: The most common application for a work capacity evaluation is to determine an individual's capability compared to his/her job and for preparation for return-to-work. A test can also be used to help an employer make reasonable accommodations if a patient has a documented disability.

d. **Job Analysis (97750)** - Description**:** Job Analysis is performed at a work site to determine physical aspects of a particular job. The job analyzes may or may not include pictures of the essential aspects of the job.

Application: Job Analysis is generally used to create work capacity evaluation to determine an individual's ability to perform specific aspects of a particular job. This can be helpful in determining an individuals ability to return to work. A job analysis can also help an employer to determine physical job descriptions, which include essential and non-essential aspects of a particular job. A Job Analysis can be used if an employer decides to perform pre-work placement tests. A Job Analysis can also be used in making appropriate ergonomic adjustments to improve the safety of a particular workstation.

97750 Job Analysis, (performed at work site) **(each 15 minutes)**
Anticipated time: variable depending on the distance traveled and job analyzed.
Pre-authorization required

8. **Evaluation Codes**

Codes 97001 and 97002 and Codes 97003 and 97004 are only to be used by physical therapists or occupational therapists respectively **when progress notes substantiate that the defined level of care was rendered.**

Code	Utah Value
97001 Physical therapy evaluation	**1.5**
97003 Occupational therapy evaluation	**1.5**
97002 Physical therapy re-evaluation	**1.0**
97004 Occupational therapy re-evaluation	**1.0**

Codes 99211 and 99212 are to be used by physicians (including chiropractors) ***only*** **when progress notes substantiate that the defined level of care was rendered.**

9. **Debridement** - as outlined in CPT Schedule

C. ANESTHESIA

1. Guidelines

a. Medicare's Base Units and methodology for time calculation (1unit for 15 min. of anesthesia) is adopted with the conversion factor of $41.00.
b. The basic value provided in the RBRVS for anesthesia when multiple surgical procedures are performed during a single anesthetic administration is the basic value for the procedure with the highest unit value. The appropriate basic value units, modifying units and time units may be applied to each anesthetic administration.
c. Services which may necessitate skills and time of the physician beyond that usually required (e.g.: unusual forms of monitoring, severe multiple injuries or other factors requiring extended pre and/or post-operative care) should be substantiated "By Special Report."
d. When it is necessary to have a second attending anesthesiologist assist with the preparation and conduct of the anesthesia, these circumstances should be substantiated "By Special Report." Such services shall have a Basic Value of 5.0 units plus Time Units.
e. The minimum basic unit value for any procedure requiring endotracheal intubation for avoidance of the surgical field or to place the patient in a prone position shall be 4.0. Where the listed basic unit value is 4 or more, no additional units are warranted for endotracheal intubation. Use Modifier -22.
f. Qualifying Circumstance codes 99100 through 99140 are not covered (NC)

2. Time Reporting

Time Units will be added to the basic value for all cases at the rate of one unit for each 15 minutes or fraction thereof.

D. SURGERY

1. Needle Procedures

a. Diagnostic needle procedures (Lumbar puncture, thoracentesis, jugular or femoral vein taps, subdural taps, etc.) when performed as part of the necessary work-up for a serious medical illness or injury should be billed in addition to the medical care on the same day.
b. Therapeutic injections are usually given in conjunction with a medical service.
c. Puncture of a cavity or joint for aspiration followed by injection of a therapeuticum is one procedure and should be billed as such.
d. Therapeutic procedures (injecting into cavities, nerve blocks, joint and tendon problems, etc.) (20550-20610; 64400-64450) may be billed in addition to the medical care on the same day for a new patient.

e. In follow up cases for additional therapeutic aspiration and/or injection when the needle procedure is the primary service, an office visit charge in conjunction with that is only indicated if there is necessary a significant re-evaluation of the patient. In this case a minimal service may be listed in addition to the injection.
f. The above-mentioned "needle" procedures do not include injections for x-ray procedures. Injection procedures in conjunction with radiological services include necessary local anesthesia, placement of needle or catheter and injection of contrast media.
g. Immunization procedures are covered only if they relate directly to an industrial injury or exposure. They are not covered for routine services or prevention.
h. Puncture for injection, drainage, or aspiration (62270-62287) and Nerve Blocks (64400-64640) are listed in the surgical section of the Relative Value Study. There is only one reimbursement value per procedure regardless of the time required or the specialty of the physician rendering the service. These services are coded and reimbursed as surgery. Anesthesia units are to be used only when a supplemental anesthetic is required to carry out the procedure.
i. Trigger Point Injections:
Regardless of the number of injections or trigger points treated, trigger point injections are reported per **muscle**. Report 20552 if one or two muscles are treated. Report 20553 if three or more muscles are treated during the treatment session. Code 20553 is the maximum allowed for any one-treatment session regardless of the number of muscles treated. Do not report both code 20552 and 20553 for the same treatment session. Documentation must indicate which muscles were treated.
Research has clarified that in this code number the word injections is plural and that is meant to include one or more injections. A reading of this descriptor will show that trigger point injections represent a much lesser procedure in general than the other procedures that justify a significant higher reimbursement than a trigger point injection. Thus injections is considered as plural and to refer to one or more injections in any extended anatomical site.

E. RADIOLOGY

1. **Two patterns of billing currently prevail in Radiology**. A total charge for the radiology service to include both professional fees and technical costs is made by radiologists working in offices, clinics and, under some circumstances, in hospital x-ray departments.
2. **In the majority of voluntary hospital radiology departments, the radiologist submits a separate statement to the patient for his professional services - using Modifier -26. The hospital charges for the technical component (TC).** A total (T) fee includes both the professional fee of the radiologist and the cost for non-physician personnel, facilities, supplies and overhead needed to accomplish the procedure. The separation of billing between the radiologist and hospital in no way implies a division of responsibility but only a needed medical service for the patient. The radiologist must retain full responsibility for his own activity and full responsibility for the supervision of the technologist, the selection and maintenance of equipment, the control of radiation hazards and the general administration of the radiology department.
3. If other physicians participate in a significant fashion in a procedure, then one must anticipate a fee for their services separate from the one asked by the radiologist.
4. The charges made by the institution cover the services of technologists and other helpers, the film, contrast media, chemicals and other materials, the use of the space and facilities of the x-ray department plus any other costs.
5. Radioisotopes, Gadolinium and comparable materials may be charged for (COM) at the provider's cost plus 15%. See 99070.
6. The professional component represents the reimbursement allowance of the professional radiological services of the physician and is identified by the use of Modifier -26. This includes examination of the patient when indicated, performance or supervision of the procedure, interpretation and written report of the examination and consultation with the referring physician.
7. The professional component is traditionally used by physicians under contract with a hospital or other facility who billed independently of the hospital or other facility. This component is payable only to the physician who renders the official interpretation or reading of the X-rays and written report. When the X-rays are reviewed by others, that service is included as a part of the basic service rendered to the patient. It is inappropriate for others to use Modifier -26 when X-rays are reviewed as part of an evaluation of a patient for an independent medical evaluation, consultation or any office visit.

F. PATHOLOGY

1. **Laboratory and Pathology:** The current RBRVS does not cover reimbursement rates for laboratory or pathology codes. These reimbursement amounts will be 150% of Utah's published Medicare carrier.
2. **The physician is allowed to bill from the RBRVS fee schedule.** A handling fee is allowed only if an outside laboratory is billing for the test. Also, a physician **may not** have a financial interest in the laboratory.

R612-2. Workers' Compensation Rules - Health Care Providers.

R612-2. Workers' Compensation Rules-Health Care Providers.

R612-2-1. Definitions.

A. All definitions in Rule R612-1 apply to this section.

B. "Medical Practitioner" - means any person trained in the healing arts and licensed by the State in which such person practices.

C. "Global Fee Cases" - are those flat fee cases where fees include pre-operative and follow-up or aftercare.

R612-2-2. Authority.

This rule is enacted under the authority of Section 34A-1-104.

R612-2-3. Filings.

A. Within one week following the initial examination of an industrial patient, physicians and chiropractors, shall file "Form 123 - Physicians' Initial Report" with the carrier/self-insured employer, employee, and the division. This form is to be completed in as much detail as feasible. Special care should be used to make sure that the employee's account of how the accident occurred is completely and accurately reported. All questions are to be answered or marked "N/A" if not applicable in each particular instance. All addresses must include city, state, and zip code. If modified employment in #29 is marked "yes," the remarks in #29 must reflect the particular restrictions or limitations that apply, whether as to activity or time per day or both. Estimated time loss must also be given in #29. If "Findings of Examination" (#17) do not correctly reflect the coding used in billing, a reduction of payment may be made to reflect the proper coding.

B. 1. Any medical provider billing under the restorative services section of the Labor Commission's adopted Resource-Based Relative Value Scale (RBRVS) or the Medical Fee Guidelines shall file the Restorative Services Authorization (RSA) form with the insurance carrier or self-insured employer (payor) and the division within ten days of the initial evaluation.

2. Upon receipt of the provider's RSA form, the payor has ten days to respond, either authorizing a specified number of visits or denying the request. No more than eight (8) visits may be incurred during the authorization process.

3. After the initial RSA form is filed with the payor and the division, an updated RSA form must be filed for approval or denial at least every six visits until a fixed state of recovery has been achieved as evidenced by either subjective or objective findings. If the medical provider has filed the RSA form per this rule, the payor is responsible for payment, unless compensability is denied by the payor. In the event the payor denies the entire compensability of a claim, the payor shall so notify the claimant, provider, and the division, after which the provider may then bill the claimant.

4. Any denial of payment for treatment must be based on a written medical opinion or medical information. The denial notification shall include a copy of the written medical opinion or information from which the denial was based. The payor is not liable for payment of treatment after the provider, claimant, and division have been notified in writing of the denial for authorization to pay for treatment. The claimant may then become responsible for payment.

5. Any dispute regarding authorization or denial for treatment will be determined from the date the division received the RSA form or notification of denial for payment of treatment.

6. The claimant may request a hearing before the Division of Adjudication to resolve compensability or treatment issues.

7. Subjective objective assessment plan/procedure (SOAP notes) or progress notes are to be sent to the payor in addition to the RSA form.

8. **[EFFECTIVE NOVEMBER 1, 1998] Any medical provider billing under the Restorative Services Section of the RBRVS or the Commission's Medical Fee Guidelines, who fails to submit the required RSA form shall be limited to payment of up to eight visits for a compensable claim. The medical provider may not bill the patient or employer for any remaining balances.**

C. S.O.A.P. notes or progress reports of each visit are to be sent to the payor by all medical practitioners substantiating the care given, the need for further treatment, the date of the next treatment, the progress of the patient, and the expected return-to-work date. These reports must be sent with each bill for the examination and treatment given to receive payment. S.O.A.P. notes are not to be sent to the division unless specifically requested.

D. "Form 110 - Release to Return to Work" must be mailed by either the medical practitioner or carrier/employer to the employee and the division within five calendar days of release.

E. The carrier/employer may request medical reports in addition to regular progress reports. A charge may be made for such additional reports, which charge should accurately reflect the time and effort expended by the physician.

R612-2-4. Hospital or Surgery Pre-authorization.

Any ambulatory surgery or inpatient hospitalization other than a life or limb threatening admission, allegedly related to an industrial injury or occupational disease, shall require pre-authorization by the employer/insurance carrier. Within two working days of a telephone request for pre-authorization, the employer/carrier shall notify the physician and employee of approval or denial of the surgery or hospitalization, or that a medical examination or review is going to be obtained. The medical examination/review must be conducted without undue delay, which in most circumstances would be considered less than thirty days. If the request for pre-authorization is made in writing, the employer/carrier shall have four days from receipt of the request to notify the physician and employee. If the employee chooses to be hospitalized and/or to have the surgery prior to such pre-authorization or medical examination/review, the employee may be personally responsible for the bills incurred and may not be reimbursed for the time lost unless a determination is made in his/her favor.

R612-2-5. Regulation of Medical Practitioner Fees.

Pursuant to Section 34A-2-407:

A. The Labor Commission of Utah:

1. Establishes and regulates fees and other charges for medical, surgical, nursing, physical and occupational therapy, mental health, chiropractic, naturopathic, and osteopathic services, or any other area of the healing arts as required for the treatment of an industrially injured employee.

2. Adopts and by this reference incorporates the National Health Care Financing Administration's (HCFA) "Resource-Based Relative Value System" (RBRVS) 2004 edition, as the method for calculating reimbursement and the American Medical Association's CPT, 2004 edition, coding guidelines. The non-facility total unit value will apply in calculating the reimbursement, except that procedures provided in a facility setting shall be reimbursed at the facility total unit value and the facility may bill a separate facility charge. The CPT-5 coding guidelines are subject to the Utah Labor Commission's Medical Fee Guidelines and Codes and the following Labor Commission conversion factors for medical care rendered for an industrial injury or occupational disease, effective July 2, 2004:

(Conversion Rates below EFFECTIVE July 2, 2004, to be used with the RBRVS procedural unit value as per specialty:]

Anesthesiology	$41.00	(1 unit per 15 minutes of anesthesia)
Medicine, E & M	$42.00	
Restorative Services	$42.00	
with Code 97001 and 97003 at 1.5 RVU		
and Code 97002 and 97004 at 1.0 RVU		
Pathology and Laboratory	150 % of Utah's published Medicare carrier	
Radiology	$53.00	
Surgery	$37.00	
Codes (all 20000 and 60000) (49505 through 49525)	$58.00	

3. Adopts and incorporates by this reference the Utah Labor Commission's Medical Fee Guidelines and Codes, as of July 2, 2003. The Utah Medical Fee Guidelines and Codes can be obtained from the division for a fee sufficient to recover costs of development, printing, and mailing.

4. Decides appropriate billing procedure codes when disputes arise between the medical practitioner and the employer or its insurance carrier. In no instance will the medical practitioner bill both the employer and the insurance carrier.

B. Employees cannot be billed for treatment of their industrial injuries or occupational diseases.

C. Discounting from the fees established by the Labor Commission is allowed only through specific contracts between a medical provider and a payor for treatment of industrial injured/ill patients.

D. Restocking fee 15%. Rule R612-2-16 covers the restocking fee.

E. Dental fees are not published. Rule R612-2-18 covers dental injuries.

F. Ambulance fees are not published. Rule R612-2-19 covers ambulance charges.

R612-2-6. Fees in Cases Requiring Unusual Treatment.

The RBRVS scheduled fees are maximum fees except that fees higher than scheduled may be authorized by the Commission when extraordinary difficulties encountered by the physician justify increased charges and are documented by written reports.

R612-2-7. Insurance Carrier's Privilege to Examine.

The employer or the employer's insurance carrier or a self-insured employer shall have the privilege of medical examination of an injured employee at any reasonable time. A copy of the medical examination report shall be made available to the Commission at any time upon request of the Commission.

R612-2-8. Who May Attend Industrial Patients.

A. The employer has first choice of physicians; but if the employer fails or refuses to provide medical attention, the employee has the choice of physicians.

B. An employee of an employer with an approved medical program may procure the services of any qualified practitioner for emergency treatment if a physician employed in the program is not available for any reason.

R612-2-9. Changes of Doctors and Hospitals.

A. It shall be the responsibility of the insurance carrier or self-insured employer to notify each claimant of the change of doctor rules. Those rules are as follows:

1. If a company doctor, designated facility or PPO is named, the employee must first treat with that designated provider. The insurance carrier or self-insured employer shall be responsible for payment for the initial visit, less any health insurance copays and subject to any health insurance reimbursement, if the employee was directed to and treated by the employer's or insurance carrier's designated provider, and liability for the claim is denied and if the treating physician provided treatment in good faith and provided the insurance carrier or self-insured employer a report necessary to make a determination of liability. Diagnostic studies beyond plain x-rays would need prior approval unless the claimed industrial injury or occupational illness required emergency diagnosis and treatment.

2. The employee may make one change of doctor without requesting the permission of the carrier, so long as the carrier is promptly notified of the change by the employee.

(a) Physician referrals for treatment or consultation shall not be considered a change of doctor.

(b) Changes from emergency room facilities to private physicians, unless the emergency room is named as the "company doctor", shall not be considered a change of doctor. However, once private physician care has begun, emergency room visits are prohibited except in cases of:

(i) Private physician referral, or

(ii) Threat to life.

3. Regardless of prior changes, a change of doctor shall be automatically approved if the treating physician fails or refuses to rate permanent partial impairment.

B. Any changes beyond those listed above made without the permission of the carrier/self-insurer may be at the employee's own expense if:

1. The employee has received notification of rules, or
2. A denial of request is made.

C. An injured employee who knowingly continues care after denial of liability by the carrier may be individually responsible for payment. It shall be the burden of the carrier to prove that the patient was aware of the denial.

D. It shall be the responsibility of the employee to make the proper filings with the division when changing locale and doctor. Those forms can be obtained from the division.

E. Except in special cases where simultaneous attendance by two or more medical care practitioners has been approved by the carrier/employer or the division, or specialized services are being provided the employee by another physician under the supervision and/or by the direct referral of the treating physician, the injured employee may be attended by only one practitioner and fees will not be paid to two practitioners for similar care during the same period of time.

F. The Commission has jurisdiction to decide liability for medical care allegedly related to an industrial accident.

R612-2-10. One Fee Only to be Paid in Global Fee Cases.

In a global fee case, which is transferred from one doctor to another doctor, one fee only will be paid, apportioned at the discretion of the Commission. Adequate remuneration shall also be paid to the medical practitioner who renders first aid treatment where the circumstances of the case require such treatment.

R612-2-11. Surgical Assistants' Fees.

Fees, in accordance with the Commission's adopted Resource-Based Relative Value Scale (RBRVS), in addition to the global fee for surgical services, will be paid surgical assistants only when specifically authorized by the employer or insurance carrier involved, or in hospitals where interns and residents are not available and the complexity of the surgery makes a surgical assistant necessary.

R612-2-12. Separate Bills.

Separate bills must be presented by each surgeon, assistant, anesthetist, consultant, hospital, special nurse, or other medical practitioner within 30 days of treatment on a HCFA 1500 billing form so that payment can be made to the medical practitioner who rendered the service. All bills must contain the federal ID number of the person submitting the bill.

R612-2-13. Interest for Medical Services.

A. All hospital and medical bills must be paid promptly on an accepted liability claim. All bills, which have been submitted properly on an accepted liability claim, are due and payable within 45 days of being billed unless the bill or a portion of the bill is in dispute. Any portion of the bill not in dispute is payable within 45 days of the billing.

B. Per Section 34A-2-420, any award for medical treatment made by the Commission shall include interest at 8% per annum from the date of billing for the medical service.

R612-2-14. Hospital Fees Separate.

Fees covering hospital care shall be separate from those for professional services and shall not extend beyond the actual necessary hospital care. When it becomes evident that the patient needs no further hospital treatment, he/she must be discharged. All billings must be submitted on a UB92 form and be properly itemized and coded and shall include all appropriate documentation to support the billing. There shall not be a separate fee charged for the necessary documentation in billing for payment of hospital services. The documentation of hospital services shall include at a minimum the discharge summary. The insurance carrier may request further documentation if needed in order to determine liability for the bill.

R612-2-15. Charges for Ordinary Supplies, Materials, or Drugs.

Fees covering ordinary dressing materials or drugs used in treatment shall not be charged separately but shall be included in the amount allowed for office dressings or treatment.

R612-2-16. Charges for Special or Unusual Supplies, Materials, or Drugs.

A. Charges for special or unusual supplies, materials, or drugs not included as a normal and usual part of the service or procedure shall, upon receipt of an itemized and coded billing, be paid at cost plus 15% restocking fees.

B. For purposes of part A above, the amount to be paid shall be calculated as follows:

1. Applicable shipping charges shall be added to the purchase price of the product:
2. The 15% restocking fee shall then be added to the amount determined in sub part 1:
3. The amount of taxes paid on the purchase of the supplies, materials, or drugs shall then be added to the amount determined in sub part 2, which sum shall constitute the total amount to be paid.

R612-2-17. Fees for Unscheduled Procedures.

Fees for medical or surgical procedures not appearing in the Commission's adopted RBRVS current fee schedule are subject to the Commission's approval and should be submitted to the Commission when the physician and employer or insurance carrier do not agree on the value of the service. Such fees shall be in proportion as nearly as practicable to fees for similar services appearing in the RBRVS.

R612-2-18. Dental Injuries.

Where a worker sustains an accident in the course of his employment resulting in the loss of or injury to teeth, making dental work necessary, the injured worker shall consult a dental surgeon and receive such first aid as may be necessary to preserve, if possible, the normal function of the injured teeth. The dental surgeon shall then file with the insurance carrier a report setting forth the nature of the injury together with an estimate of the cost of restoration. The dental surgeon shall not proceed with the restoration until authority has been granted by the insurance carrier, provided, however, that if an employer maintains a medical staff or designates a company doctor, the employee shall first report to that medical staff or medical officer and be guided by directions then given. If the carrier refuses payment at the level estimated by the dental surgeon, the employee may choose to pay the difference and seek adjudication by Application for Hearing. A dental surgeon may choose to settle for the payment allowed, or the carrier shall direct the employee to a dental surgeon who will provide his services at the payment level specified by the carrier.

R612-2-19. Ambulance Charges.

Ambulance charges must not exceed the rates adopted by the State Emergency Medical Service Commission for similar services.

R612-2-20. Travel Allowance and Per Diem.

A. An employee who, based upon his/her physician's advice, requires hospital, medical, surgical, or consultant services for injuries arising out of and in the course of employment and who is authorized by the self-insurer, the carrier, or the Commission to obtain such services from a physician and/or hospital shall be entitled to:

1. Subsistence expenses of $5 per day for breakfast, $6 per day for lunch, $10 per day for dinner, and actual lodging expenses as per the state of Utah's in-state travel policy provided:

(a) The employee travels to a community other than his/her own place of residence and the distance from said community and the employee's home prohibits return by 10:00 p.m., and

(b) The absence from home is necessary at the normal hour for the meal billed.

2. Reasonable travel expenses regardless of distance that are consistent with the state of Utah's travel reimbursement rates, or actual reasonable costs of practical transportation modes above the state's travel reimbursement rates as may be required due to the nature of the disability.

B. This rule applies to all travel to and from medical care with the following restrictions:

1. The carrier is not required to reimburse the injured employee more often than every three months, unless
   (a) More than $100 is involved, or
   (b) The case is about to be closed.
2. All travel must be by the most direct route and to the nearest location where adequate treatment is reasonably available.
3. Travel may not be required between the hours of 10:00 p.m. and 6:00 a.m., unless approved by the Commission.
4. Requests for travel reimbursement must be submitted to the carrier for payment within one year of the authorized medical care.
5. Travel allowance shall not include picking up prescriptions unless documentation is provided substantiating a claim that prescriptions cannot be obtained locally within the injured worker's community.
6. The Commission has jurisdiction to resolve all disputes.

R612-2-21. Notice to Health Care Providers.

Any notice from a carrier denying further liability must be mailed to the Commission and the patient on the same day as it is mailed to the health care provider. Where it can be shown, in fact, that a medical care provider and the injured employee have received a denial of further care by the insurance carrier or self-insured employer, further treatment may be performed at the expense of the employee. Any future ratification of the denial by the Commission will not be considered a retroactive denial but will serve to uphold the force and effect of the previous denial notice.

R612-2-22. Medical Records.

A. When any medical practitioner provides copies of medical records to the parties of an industrial case, the following charges are presumed reasonable:

1. A search fee of $15 payable in advance of search,
2. Copies at $0.50 per page including copies of microfilm payable after the records have been prepared, and
3. Actual costs of postage payable after the records have been prepared. Actual costs of postage are deemed to be the cost of regular mail unless the requesting party has requested the delivery of the records by special mail or method.

B. Those persons or entities who are entitled to copies of medical records involving an industrial case are:

1. The injured employee or his/her dependents,
2. The employer of the injured worker,
3. The employer's workers' compensation insurance carrier,
4. The Uninsured Employers' Fund,
5. The Employers' Reinsurance Fund,
6. The Commission, and
7. Any attorney representing any of the above in an industrial injury or occupational disease claim.

C. No other person or entity is entitled to medical records unless ordered by a Court or provided with a notarized release executed by the injured worker.

D. The Commission will operate in the release of its records to the parties/entities as specified above unless the information is classified as confidential under the Government Records Access and Management Act (GRAMA).

E. No fee shall be charged when the RBRVS requires specific documentation for a procedure or when physicians and surgeons are required to report by statute or rule.

F. An injured workers may obtain one of each of the following records related to the industrial injury or occupational disease, at no cost, when the injured worker or his/her dependents have a signed form by the division to substantiate his/her industrial injury/illness claim:

1. History and physical,
2. Operative reports of surgeries,
3. Discharge summary, and
4. Emergency room records,
5. Radiological reports,
6. Specialized testing results, and
7. Physician SOAP notes, progress notes, or specialized reports.

(a) Alternatively, a summary of the patient's record may be made available to the claimant at the discretion of the physician.

8. And such other records as may be requested by the Commission in order to make a determination of liability.

R612-2-23. Adjusting Relative Value Schedule (RVS) Codes.

A. When adjusting any medical provider's bill that has billed per the Commission's RBRVS, the adjusting entity shall provide one or more of the following explanations as applies to the down coding when payment is made to the medical provider:

1. Code 99202, 99203, 99204 or 99205 - the submitted documentation for a new patient did not meet the three key components lacking in the level of history for the code billed.

2. Code 99202, 99203, 99204 or 99205 - the submitted documentation for a new patient did not meet the three key components lacking in the level of examination for the code billed.

3. Code 99202, 99203, 99204 or 99205 - the submitted documentation for a new patient did not meet the three key components lacking in the level of medical decision making for the code billed.

4. Code 99202, 99203, 99204, or 99205 - the submitted documentation for a new patient did not meet the three key components lacking in the level of history and exam for the code billed.

5. Code 99213, 99214 or 99215 - the submitted documentation for an established patient did not meet the two key components lacking in the level of history and exam that the code billed.

6. Code 99213, 99214 or 99215 - the submitted documentation for an established patient did not meet the two key components lacking in the level of history and medical decision making for the code billed.

7. Code 99213, 99214 or 99215 - the submitted documentation for the established patient did not meet the two key components lacking in the level of exam and medical decision making for the code billed.

B. The above explanations may be abbreviated, with a legend provided, to accommodate the space of computerized messages.

R612-2-24. Review of Medical Payments.

A. Health care providers and payors are primarily responsible to resolve disputes over fees for medical services between themselves. However, in some cases it is necessary to submit such disputes to the Division for resolution. The Commission therefore establishes the following procedure for submission and review of fees for medical services.

1. The provider shall submit a bill for services rendered, with supporting documentation, to the payor within one year of the date of service.

2. The payor shall evaluate the bill according to the guidelines contained in the Commission's Medical Fee Guidelines and RBRVS and shall pay the provider the appropriate fee within 45 days as required by Rule R612-2-13.

3. If the provider believes that the payor has improperly computed the fee under the RBRVS, the provider or designee shall request the payor to re-evaluate the fee. The provider's request for re-evaluation shall be in writing, shall describe the specific areas of

disagreement, and shall include all appropriate documentation. The provider shall submit all requests for re-evaluation to the payor within one year of the date of the original payment.

4. Within 30 days of receipt of the written request for re-evaluation, the payor shall either pay the additional fee due the provider or respond with a specific written explanation of the basis for its denial of additional fees. The payor shall maintain proof of transmittal of its response.

B. If the provider continues to disagree with the payor's determination of the appropriate fee, the provider shall submit the matter to the Division by filing with the Division a written explanation of the disagreement. The provider's explanation shall include copies of:

1. The provider's original bill and supporting documentation;
2. The payor's initial payment of that bill;
3. The provider's request for re-evaluation and supporting documentation; and
4. The payor's written explanation or its denial of additional fees.

C. The Division will evaluate the dispute according to the requirements of the Medical Fee Guidelines and RBRVS and, if necessary, by consulting with the provider, payor, or medical specialists. Within 45 days from the date the Division receives the provider's request, the Division will mail its determination to both parties.

D. Any party aggrieved by the Division's determination may file an application for hearing with the Division of Adjudication to obtain formal adjudication of the dispute.

E. A payor seeking reimbursement from a provider for overpayment of a bill shall submit a written request to the provider detailing the circumstances of the payment requested within one year of submission of the bill.

1. Providers should make appropriate reimbursements, or respond in writing detailing the reasons why repayment will not be made, within 90 days or receipt of a written request from a payor.

2. If a dispute as to reimbursement occurs, an aggrieved party may request resolution of the dispute by the Labor Commission.

612-2-25. Injured Worker's Right to Privacy.

A. No agent of the employer or the employer's insurance carrier shall be present during an injured worker's visit with a medical provider, unless agreed upon by the claimant.

B. If an agent of the employer or the employer's insurance carrier is excluded from the medical visit, the medical provider and the injured worker shall meet with the agent at the conclusion of the visit so as to communicate regarding medical care and return to work issues.

R612-2-26. Utilization Review Standards.

A. As used in this subsection:

1. "Payor" means a workers' compensation insurance carrier, a self-insured employer, third-party administrator, uninsured employer or the Uninsured Employers' Fund, which is responsible for payment of the workers' compensation claim.

2. "Health Care Provider" means a provider of medical services, including an individual provider, a health-service plan, a health-care organization, or a preferred-provider organization.

3. "Request for Authorization" means any request by a physician for assurance that appropriate payment will be made for a course of proposed medical treatment, including surgery or hospitalization, or any diagnostic studies beyond plain X-rays.

4. "Utilization Review" as authorized in Section 34A-2-111, is a process used to manage medical costs, improve patient care, and enhance decision-making. Utilization review includes, but is not limited to, the review of requests for authorization to treat, and the review of bills, for the purpose of determining whether the medical services provided were or would be necessary, to treat the effects of the injury/illness. Utilization review does not include bill review for the purpose of determining whether the medical services rendered were accurately billed. Nor does it include any system, program, or activity in connection with making decisions concerning whether a person has sustained an injury or illness that is compensable under Section 34A-2 or 34A-3.

5. "Reasonable Attempt" is defined as at least two phone calls and a fax, or three phone calls, within five business days from date of the payor's receipt of the physician's request for review.

B. Any utilization review system shall establish an appeals process, which utilizes a physician(s) for a final decision by the insurer, should an initial review decision be contested. The payor may establish levels of review that meet the following criteria:

1. Level I--Initial Request and Review. A payor may use medical or non-medical personnel to initially apply medically-based criteria to a request for authorization for payment of a specific treatment. The treating physician must send all the necessary documentation for the payor to make a decision regarding the treatment recommended. The payor must then notify the physician within five business days of the request for authorization of payment for the treatment, by a method that provides certification of transmission of the document, of either an acceptance or a denial of the request. **A denial for authorization of payment for a recommended treatment, utilizing the Commission's Form 223, must be sent to the provider with the criteria used in making the determination to deny payment for the treatment**. A copy of the denial must also be mailed to the claimant. Level I-- Request and Review does not include authorization requests for services billed from the Restorative section of the Resource-Based Relative Value Schedule (RBRVS). Requests for authorization for restorative services are governed by rule R612-2-3(B).

2. Level II--Review. **A physician, who has been denied authorization of payment for treatment, or has received no response within five business days from the request for authorization for payment at Level I review, may request a physician's review by sending the completed portion of the Commission form 223 to the payor.** Such a request for review may be filed by any physician who has been denied authorization for payment for restorative services beyond the initial eight visits as authorized by Rule R612-2-3(B). The requesting physician must include the times and days that he/she is available to discuss the case with the reviewing physician, and must be reasonably available during normal business hours. The payor's physician representative must complete the review within five business days of the treating physician's request for review. Before the insurer's physician representative may issue a denial of an authorization for payment to treat, a reasonable effort must have made to contact the requesting treating physician to discuss the differing aspects of the case. Failure by the payor to respond within five business days, by a method that provides certification of transmission, to a denial for authorization for payment for treatment, shall constitute an authorization for payment of the treatment. The payor's denial to pay for the recommended treatment must be issued on Commission's form 223, and the denial must be accompanied by the criteria that was used in making the decision to deny authorization, along with the name and speciality of the reviewing physician. The denial to authorize payment for treatment must then be sent to the physician, the claimant, and the Commission. The payor shall notify the Commission if an additional five days is needed in order to contact the treating physician or to review the case. An additional extension of time may be requested from the Commission to accommodate highly unusual circumstances or particularly difficult cases.

C. Upon receipt of denial of authorization for payment for medical treatment at Level II, the Commission will facilitate, upon the request of the claimant, the final disposition of the case. If the parties agree, the medical dispute may be resolved by the Commission through binding mediation or medical review. If there is not agreement among the parties, the Commission will resolve the dispute through formal adjudication. The payor shall be responsible for sending the claimant the Commission appeals information when the denial for authorization for payment for medical treatment is sent to the claimant.

D. If the medical treatment requested is not an emergency, and treatment is rendered by the physician after receiving notice of the utilization standards encompassed in this rule, the following shall apply:

1. The Commission shall, if the disputed medical treatment is ultimately determined to be compensable as an expense necessary to treat the industrial injury or occupational disease, order that the physician be reimbursed at only 75% of the of the amount otherwise payable had appropriate authorization been timely obtained. The injured worker shall not be liable for any additional payment to the physician above the 75%.

2. Neither the worker's employer or its workers' compensation insurer shall be liable for any portion of the cost of disputed medical treatment, if that treatment is ultimately determined not to be compensable as an expense necessary to treat an industrial injury or occupational disease.

3. A worker may become liable for the cost of the disputed medical treatment, if that treatment is ultimately determined not to be compensable as an expense necessary to treat the industrial injury or occupational disease.

4. Except for any co-pays or deductibles under the worker's health insurance plan, the penalty provision in D(1) and D(3) shall not apply if the physician performs the medical treatment in question, having been preauthorized in writing to do the same by a health insurer or other non-worker's compensation insurance payor.

5. The penalty provisions in D(1) shall not apply to medical treatment rendered in emergency situations, which are defined as a threat to life or limb.

6. The Commission shall notify a physician, in writing, of reported violations of this rule. Repeated violations of this rule by a physician may result in a report from the Commission to the Department of Commerce, Division of Occupational/Professional Licensing.

SUTURE AND SURGICAL SUPPLY TRAYS

1. MINOR: (Includes all prep supplies) $30.00
   - Hemostat
   - Medicine cup
   - 2 Drapes
   - 1 Needle holder
   - 1 Suture pack
   - 6 4x4 Gauze sponges
   - 1 Pick up
   - 1 2' Kling
   - 1 3' Ace

2. INTERMEDIATE: (Includes all prep supplies) $48.00
   - All of the above including
   - 1 Extra hemostat
   - 2 Skin hooks
   - 2 Retractors
   - 3 Suture packs
   - 1 Mayo
   - 4 Drapes total
   - Penrose
   - Iodoform gauze
   - 4 Towel clips
   - 1 Ronguer
   - 1 Bone curette
   - 1 Simple metal splint

3. MAJOR PLASTIC: (Includes all prep supplies) $72.00
   - All of the above including
   - 3 Ten pack 4x4's
   - Kling
   - 2 Adaptics
   - 2 Aces
   - 6 packs suture total

SURGICAL SUPPLY TRAY

PROCEDURE	NOMENCLATURE	PROCEDURE CODE

Repair - Simple
(Sum of lengths of repairs)

11750	Excision of Nail and Nail matrix, partial or complete	**Minor**
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet) up to 2.5 cm	**Minor**
12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm to 7.5 cm	**Intermediate**
12004	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.5 cm to 12.5 cm	**Intermediate**
12005	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.5 cm to 20.0 cm	**Intermediate**
12006	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.0 cm to 30.0 cm	**Major**
12007	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm	**Major**
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes: up to 2.5 cm	**Intermediate**
12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes: 2.5 cm to 5.0 cm	**Intermediate**
12037	Layer closure of wounds of scalp, axillae, trunk and/or extremities(excluding hands and feet); over 30.0	**Major**
12041	Layer closure of wounds of neck, hands, feet and/or external genitalia; up to 2.5 cm	**Intermediate**
12042	Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.5 cm to 7.5 cm	**Major**
12044	Layer closure of wounds of neck, hands, feet and/or external genitalia; 7.5 cm to 12.5 cm	**Major**
12045	Layer closure of wounds of neck, hands, feet and/or external genitalia; 12.5 cm to 20.0 cm	**Major**
12046	Layer closure of wounds of neck, hands, feet and/or external genitalia; up to 2.0 cm to 30.0 cm	**Major**
12047	Layer closure of wounds of neck, hands, feet and/or external genitalia; over 30.0 cm	**Major**
12051	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; up to 2.5 cm	**Intermediate**
12052	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm to 5.0 cm	**Intermediate**
12053	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.0 cm to 7.5 cm	**Major**
12054	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.5 cm to 12.5 cm	**Major**
12055	Layer closure of wound of face, ears, eyelids, nose, lips and/or mucous membranes; 12.5 cm to 20.0 cm	**Major**
12056	Layer closure of wound of face, ears, eyelids, nose, lips and/or mucous membranes; 20.0 cm to 30.0 cm	**Major**

PROCEDURE	NOMENCLATURE	PROCEDURE CODE
12057	Layer closure of wounds of face, ears, eyelids, nose, lips and mucous membranes; 30.0 cm	**Major**
13100-13300		**Major**
20200	Biopsy, muscle; superficial	**Major**
20220	Biopsy, bone, trocar or needle; superficial (e.g., Ilium, Sternum, Spinous Process, Ribs)	**Intermediate**
25000	Tendon Sheath incision; at radial styloid for deQuervain's disease	**Major**
25100	Arthrotomy, wrist, joint; for biopsy	**Intermediate**
25130	Excision or curettage of bone cyst or benign tumor of carpal bones	**Intermediate**
26055	Tendon sheath incision for trigger finger Major	**Intermediate**
26123	Fasciectomy, partial palmer	**Major**
26160	Excision of lesion of tendon sheath or capsule (e.g. cyst or ganglion)	**Major**
27323	Biopsy, soft tissues; superficial	**Minor**
27330	Arthrotomy, knee; for synovial biopsy only	**Major**
27332	Arthrotomy, knee; for excision of semilunar cartilage (meniscectomy): medial or lateral	**$75.00**
27340	Excision of prepatellar bursa	**Intermediate**
27620	Arthrotomy, ankle biopsy	**Intermediate**
28020	Arthrotomy, with exploration, drainage or removal of loose or foreign body, intertarsal or tarsometatarsal joint	**Intermediate**
28080	Excision of Morton neuroma, single, each	**Intermediate**
28090	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion); foot	**Intermediate**
28110	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)	**Major**
28270	Capsulotomy for contracture; metatarsophalangeal joint, with or without tenorrhaphy, single each joint (separate procedure)	**Major**
28285	Hammertoe Operation	**$75.00**
28306	Osteotomy First Metatarsal	**$75.00**
28308	Osteotomy, other than First Metatarsal	**$75.00**
28312	Osteotomy, other phalanges, any toe	**$75.00**
29870	Arthroscopy, knee, diagnostic (separate procedure)	**$55.00**
Respiratory		
30115	Excision, nasal polyp(s), extensive; unilateral	**Minor**
30130	Excision turbinate, partial or complete	**Major**
30140	Submucous resection turbinate, partial or complete	**Major**
31020	Sinusotomy, Maxillary, intranasal	**Major**
31526	Laryngoscopy direct; diagnostic, with operating microscope	**$35.00**
31575	Laryngoscopy, flexible fiberscopic; diagnostic	**$35.00**
Lymphnodes and Lymphatic Channels		
38500	Biopsy or excision of lymph node(s); superficial (separate procedure)	**Minor**

SURGICAL SUPPLY TRAY

PROCEDURE	NOMENCLATURE	PROCEDURE CODE
Digestive System		
40500	Vermilionectomy (lip shave), with mycosal advancement	**Minor**
40810	Excision of lesion of mucosa and submucosa; with repair	**Intermediate**
40812	Excision of lesion of mucosa and submucosa; with simple repair	**Intermediate**
41800	Drainage abscess, cyst hematoma, dentoalveolar	**Minor**
42660	Dilation and catheterization of salivary duct, with or without injection	**Minor**

EAR TRAY

Ear Cup Bowl Syringe Alligator Forceps Acetic Acid Solution Suction Tip Catheter Ear Wicks Cotton Plugs Hydrogen Peroxide 2 Towels (Minimum Requirements)	$10.00

EYE TRAY

Pontocaine (or acceptable substitute) Q-Tips Lid Retractor Fluorescein Dye Patching of the Eye	$10.00
Ophthalmo-Burrs	$9.00
Antibiotic Medications (Garamycin) Mydriatics	$5.00
Morgan lens with intravenous set-up includes 1 liter of fluid	$26.00
Other intravenous set-up and tubing includes 1 liter of fluid	$21.00

IONTOPHOORESIS SUPPLIES

electrodes/jells/medication	$13.00